Disciplining the depressed? Considering contemporary treatments of depression as disciplinary techniques

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Abstract

This study has many different features just like the object with which it grapples – depression and its treatment. The study can be considered multiple yet singular in the same way depression can. It begins by exploring some of the current conceptualisations of depression and the differing theoretical perspectives held. From here, a brief historical sketch is laid out, examining some of the discontinuities in depression's history, and highlighting the need to situate depression both socially and historically. The focus then shifts to the contemporary climate surrounding the treatment of depression and to Michel Foucault's disciplinary techniques. These techniques are used as analytical tools and applied to four current treatments of depression: computerised cognitive behavioural therapy, guided self-help, cognitive behavioural therapy and behavioural activation. The analysis shows that in many ways these treatments do align with, and thus can be considered, disciplinary techniques. This increases the importance of considering issues of politics and power in relation to how people with depression are treated. However, this does not tell the full story; looking solely at disciplinary techniques does not capture the complexity of today's treatments of depression. In attempting to adopt a conceptual approach that can speak to and complement clinical work, the notion of multiplicity is then discussed as a way of retaining the important insights of Foucault's work but also attending to the specific clinical practices that make depression what it is today.

Introduction

From 1676 to 1825 the entrance to the London Royal Bethlem Hospital, infamously known as Bedlam, was guarded by two statues personifying madness: melancholy and raving (British Broadcasting Corporation, n.d.). These life-size, muscular, male representations of madness, sculpted by Caius Gabriel Cibber, show the two polar opposites of madness as conceptualised in pre-modern times.[1] But, also, they imply treatments. Raving is enraged, needing to be bound in chains for his own safety, and, seemingly, for the safety of others. Melancholy needs no such chains and can be left to his own devices. He is distraught, his pain directed inwards, struck with grief and hopelessness. So we see two figures that are foreign yet at once familiar, and we are reminded of mental illness in our own age, with our own treatments, which are, perhaps, just as peculiar as those of the past.

In the present day there is no mental illness with such ubiquity as depression – the object of this study. According to the World Health Organization (WHO), depression was the leading cause of disability in 2000, and is predicted to be the second highest contributor to the global burden of disease by 2020 (n.d., Depression).[2] Depression is therefore viewed as a major global problem. Some talk of it as a "social and economic timebomb" (Dawson & Tylee, 2001, p. iii), others describe the current period as the "era of great depression" (Rousseau, 2000, p. 71). As a result, depression has become part of the vernacular, easily used without a definition, and seemingly self-evident. Given this, it would be reasonable to assume that depression is well understood, unanimously agreed upon, and stable and enduring. However, things are not quite so simple.

Theoretical groundwork

Before approaching depression as an object, it is necessary to do a bit of theoretical groundwork. Firstly, the process of considering depression in this way may unintentionally imply that depression can be known outside any social and historical context. While some may consider this reasonable, one of the central features of this study is that it is informed by, and aims to further evidence, the view that psychiatric objects, like depression, need to

[1] For an original, elucidating description of the function of representation during the Classical Age, roughly coinciding with the life of these statues, see Foucault (1970).

[2] The leading cause of disability statistic is based upon the estimated years lost due to disability, and the global burden statistic is based upon the estimated years of healthy life lost (see WHO (n.d.) for more details).

be situated in order for them to be comprehensively understood. This requires attending to the theoretical positions underpinning conceptualisations of depression, and the, often competing, practical issues surrounding depression. As this study will show, depression has, at different points in time, been described, deployed and interacted with from a range of perspectives: psychiatric, psychological, medical, pharmacological, political, social constructionist, critical realist, and patient/sufferer amongst others. I will add to this by considering current treatments of depression in relation to Michel Foucault's disciplinary techniques.

There have, therefore, been many versions of depression which differ depending upon the specific field (psychiatric, social constructionist etc) and historical location from which they emerge – depression is a synchronically and diachronically shifting object. These differing positions are important, they are not mutually exclusive; instead, they overlap and interact depending upon each position's power and influence. Yet our concept of depression seemingly remains coherent despite the complex web in which it is entangled. Rather than making an argument for one position over the others, I will attempt to capture the complexity of this situation by drawing upon Annemarie Mol's (2002) elaboration of multiplicity in *The Body Multiple*. Here, Mol, influenced by Foucault amongst others, describes atherosclerosis as an object of multiplicity. In this context, Mol wants multiple to be understood as "manyfoldedness, but not pluralism. In the hospital *the body* (singular) is *multiple* (many)" (p. 84). The important point is that multiplicity is not fragmented, but held together. It is singular and multiple at the same time.

I will revisit Mol's analysis after considering depression, its treatment and Foucault's disciplinary techniques in relation to these treatments. In so doing, I will attempt to show that multiplicity is a sophisticated way of engaging with depression and its treatment which has the potential to enhance both theoretical and clinical approaches.

Depression as object

A review of the two current leading sources for diagnostic criteria, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR, henceforth DSM) and the *International Statistical Classification of Diseases and Related Health Problems* (ICD-10), shows that depression is far from straightforward.

Firstly, within the DSM, the classification is not depression but the Depressive Disorders, of which there are three: Major Depressive Disorder, Dysthymic Disorder (a

long lasting but less severe form of Major Depressive Disorder) and Depressive Disorder Not Otherwise Specified (American Psychiatric Association, henceforth APA, 2000).

Major Depressive Disorder can be either a single episode or recurrent. It is diagnosed when a person experiences the presence of at least five symptoms from a maximum of nine, one of which must be diminished interest or pleasure. The symptoms must be present for at least two weeks and lead to an impairment in functioning. The nine symptoms are: depressed mood; diminished interest or pleasure in activities; significant change in weight or appetite; insomnia or hypersomnia; psychomotor agitation or retardation; fatigue or loss of energy; feelings of worthlessness or inappropriate guilt; reduced ability to think, concentrate or make decisions; and, lastly, recurrent thoughts of death, suicidal ideation, attempts or plans (p. 356). This disorder is differentiated according to severity which is based upon the number of symptoms a person experiences, the severity of the symptoms, and the degree of impairment and distress (p. 412). Major depressive disorder, then, is a heterogeneous condition that affects sufferers in numerous ways.

The ICD-10 criterion is similarly based upon the presence of a certain number of symptoms for a certain period of time. However, it does differ from the DSM in some areas. For instance, a diagnosis of mild depressive episode requires four symptoms as opposed to five in the DSM (WHO, 1992; APA, 2000). As evident from both the DSM and the ICD-10 criteria, and as stated in the latter, mood disorders are differentiated from one another and diagnosed based upon "clinical descriptions of emotions and behaviour" (WHO, 1992, p. 13).

So depression is far from unitary and there is some disagreement between the two leading nomenclatures. An updated edition of the DSM is due for release in May 2013 (APA, n.d.(a)). Mood disorders are due to be renamed depressive disorders. Also, a new disorder, Premenstrual Dysphoric Disorder, is being proposed for inclusion, and Mixed Anxiety/Depression is being suggested as a condition for future research (APA, n.d.(b)). The former offers a reminder of the long-dominant association between womanhood and depression (see below); while the latter could be read as evidence of the timeliness of the recent *Improving Access to Psychological Therapies* programme established to treat depression and anxiety disorders within England (Clarke et al., 2009). On the other hand, it also echoes Healy's (2004) work which provides examples of disorders being marketed in order to sell certain pharmacological treatments, rather than drugs being developed, and then marketed, to treat pre-existing disorders. These ongoing changes suggest that depression is, at least to some extent, in flux.

The view proposed by the DSM is not accepted by all. From a social constructionist perspective, depression is viewed as a problem at the societal level and not as a problem with the inner psychology of the individual (Burr, 2003). Or, put another way, "depression is not an individual disorder; an individual 'does depression' as a culturally intelligible action within a context of relationship" (Gergen, 1999, p. 137). This view advocates examining the discourses structuring people's lives, the ways in which these may be unhelpful, and finding ways to resist or restructure oppressive discourses (Burr, 2003, pp. 122-123).

There are also those who view the reality of depression as being produced by the biomedical industry, in part due to the increase in diagnosis of depression paralleling the availability of pharmacological treatments (Borch-Jacobsen, 2009). As Healy (2001) explains, this position is further supported by the fact that anxiety disorders dominated primary care diagnoses until the 1980s when benzodiazepines, the leading treatment for anxiety at the time, became viewed as problematic for a number of reasons including fears of dependence. Selective serotonin reuptake inhibitors, which had recently been developed, were then marketed as antidepressants, although they could easily have been marketed as anxiolytics, leading to depression taking over anxiety's position of dominance.[3] From this view, a change in treatment would lead to a change in the condition.

Alternatively, Pilgrim and Bentall (1999) offer a critical realist perspective on depression as a way of emphasising the cultural and historical relativity of emotional states while retaining the importance of empirical investigations of distress. This allows them to view depression as "a professional reification about human misery, not a fact" and to call for a review of depression conceptually to increase its scientific and clinical utility (p. 271). One suggested way of reconceptualising depression is to both broaden and narrow its application; broadening depression allows a thorough engagement with socio-political contributors while narrowing it allows specific behaviours and experiences, such as anhedonia, that occur in particular contexts to be researched in more detail.

A glance at the past

This picture of depression remains incomplete. Recent work has shown that in order to understand psychiatric and psychological knowledge it is necessary to consider the

[3]This is to slightly simplify matters as Rasmussen (2008) has shown that antidepressants have been important to pharmaceutical companies since the 1940s when amphetamines were sold widely as antidepressants.

role of social and historical processes (Hacking, 1995 and Kusch, 1999 being two exemplars). That is, in order to reach a sophisticated understanding of something like depression, it is necessary to situate it – discursively and historically. This is a tall order when considering contemporary issues as certain concepts are more likely to be taken for granted than they would be in historical or cross-cultural research. Nevertheless, attempting to situate contemporary depression requires a consideration of its historical trajectory.

Turning to depression's history we see a process of ongoing reconceptualisation, making the planned DSM modifications to depression appear as the rule rather than the exception. The actual word depression, before being used in psychiatric discourse, was used in physical medicine where it referred to reduced cardiovascular function. Psychiatrists adopted this word to refer to emotional states which opposed excitation (Bentall, 2003, pp. 213-214).

As a disorder, depression emerged from the now antiquated melancholia.[4] Given that melancholia can be traced back to the ancient Greeks, it would be easy to conceive of melancholia, and by extension depression, as a stable, enduring form of mental illness. However, this would be anachronistic and "only chronicle the history of the pertinent words" (Berrios, 1995, p. 384). This is because, from Antiquity to the Renaissance, melancholia was regarded as a severe, intellectual form of madness which incorporated delusions (Porter, 1995). Sadness and dejection were not necessary symptoms, despite occasional references to them (Berrios, 1988).

In the second half of the nineteenth century, the concept of melancholia was transformed via the influence of faculty psychology, the clinico-anatomical model and importance being granted to subjective experiences of madness (Berrios, 1995). Increasingly, melancholia was thought of primarily as an affective disorder. These changes created the conditions for Kraepelin's concept of manic-depressive insanity in the 1920s (Berrios, 1995). This marked a significant point of departure from previous conceptions of melancholia. The dissolution of neurasthenia after the first-world war, which became

[4] In other regards, melancholia is still with us. The DSM contains a subcategory of Major Melancholic Disorder and there is some talk of resurrecting melancholia as a form of mood disorder (see Shorter, 2007 for example).

subsumed by the well-known shell-shock, was a further key factor in establishing the conditions for depression to flourish (Pilgrim & Bentall, 1999).[5]

Kraepelin's manic-depressive insanity was one half of his proposed division of mental disorders into two main forms of illness, the other being dementia praecox. Kraepelin's view that studying symptoms of mental diseases would enable the accurate discovery of disorders and their aetiology led to his concept of manic depressive insanity (Bentall, 2003). This was an overarching category of insanity which contained a variety of depressive states: melancholia simplex, stupor, melancholia gravis, paranoid melancholia, fantastic melancholia and delirious melancholia (Kraepelin, 1921). Kraepelin's concept meant that patients could be differentiated according to prognosis and symptoms; the latter ranging from feeling tired through to terrifying hallucinations (Lawlor, 2012). His work was of such magnitude that "in Europe, every view on the affective disorders since 1896 has defined itself with reference to him" (Healy, 1997, p. 37). And some view the emergence of two classes of psychotropic drugs in the 1950s, antipsychotics and antidepressants, as "the ultimate vindication of … [Kraepelin's] point of view" (p. 37).

However, Kraepelin's ideas were not immediately embraced by all within psychiatry; in many ways, his views took a back seat during large parts of the twentieth century in relation to psychoanalysis – another of the major influences upon twentieth century psychiatry. This provides an important lesson in historical understanding. It is not the case that historical change simply represents progress, development or that we are getting closer to the truth or essence of depression.[6] Rather, historical change is more the outcome of a complex web of power relations – in this instance between psychoanalytic and biological approaches to psychiatry. It is only retrospectively that the outcome can be viewed as having been inevitable. Forrester (1980), in one of his many studies of the history of psychoanalysis, makes an analogous point: "in history, as in psychoanalysis, one understands what comes before through what came after" (p. 212).

Following the development of antidepressants, Kraepelin's work became increasingly significant and the legacy of his work remains today (Healy, 1997). While aspects of his category of manic depressive insanity may seem foreign to modern eyes, the

[5]Neurasthenia remains an important diagnosis in China indicating cross-cultural variation in conceptualising what we call depression (Kleinman, 1988).

[6] Such a 'Whiggish', 'progressivist' or 'celebratory' approach to history has been necessarily problematised by historians of science since the 1960s (Richards, 2010).

influence of his method of developing disorders from clusters of symptoms can be clearly seen in the DSM criteria discussed above. Moreover, contemporary American psychiatry is dominated by a neo-Kraepelinian school of thought, further illustrating the substantial influence of Kraepelin's ideas on contemporary understandings of depression and other psychiatric objects (Healy, 1997).

Kraepelin's emphasis on manic-depressive insanity being a form of illness also influenced subsequent distinctions between depressive neuroses and psychoses. He even pointed to psychogenic states of depression caused by environmental factors as distinct from manic-depressive insanity (Shorter, 2007). This distinction was reinforced, albeit from a contradictory perspective, through psychoanalysis. Freud's admission that psychoanalysis may successfully treat neurosis but not psychosis "helped to suggest, at least in the public mind, a *de facto* distinction between depression, or neurosis indicated as a functional disorder, and psychosis…as organic" (Porter, 1995, p. 419). This division is peculiar to the West, with sufferers in Communist China representing their condition in physical terms, hence demonstrating "that which is psychiatrically thinkable in patient/doctor encounters is deeply mediated by cultural values" (p. 419).

Psychoanalytic thought offered an alternative conceptualisation of depression which had a much greater immediate impact than Kraepelin's ideas (Healy, 1997). Freud (1917) viewed melancholia as a form of loss characterised by feelings of dejection, loss of interest in the outside world, loss of the ability to love, a reduction in activity and an intense loss of self-regard. He attributed this to a psychic, rather than physical process – the unconscious transformation of anger towards a loved object into self-loathing.[7] In the United States, Meyer also moved away from Kraepelin's manic depressive insanity, criticising it for being too broad and overly focused on physical explanations difficult to prove (Lawlor, 2012). He had been arguing for melancholia to be replaced by depression since 1905, and viewed depression pragmatically as a reaction to a situation where something had gone wrong which could be treated both physically and psychologically.

Ideas from Freud and Meyer dominated mainstream British and American psychiatric practice from the 1920s to the 1970s (Lawlor, 2012). This is made further apparent by the emphasis on loss and reaction in definitions of depression in the first two editions of the DSM (APA, 1952; APA, 1968). This was to change. By the time of the

[7]Subsequent developments in psychoanalysis brought with them changes in the way depression was viewed. These are well beyond the scope of this project but see Lawlor (2012, pp. 142 – 150) for an overview.

release of the DSM-III in 1980, the influence of psychoanalysis, with its indifference to precise diagnosis, was in decline (Shorter, 2001). With the significance of psychoanalysis receding, the focus shifted to statistically analysing clusters of symptoms and, like Kraepelin, conceptualising depression as a unitary disorder.[8] According to the DSM-III, depression is a disorder of the emotions characterised by dysphoric mood, and additional psychomotor and cognitive symptoms (APA, 1980). Although this view made it difficult to distinguish between normal and abnormal states of sadness, it increased the reliability – though not necessarily the validity – of diagnosis (Lawlor, 2012).

The DSM-III criteria coincided with biological models of depression regaining the dominant theoretical position with research into the genetic basis of depression, neurotransmitters and the expansion of antidepressants as the leading treatment. Another influential view, despite differing vastly in emphasis, sought to complement not contradict this biological perspective. It views depression as a cognitive error characterised by exaggerated, negative views of the self, the world and the future (Beck, Rush, Shaw & Emery, 1979). Accordingly, depression is not caused by events themselves but by the meaning individuals inaccurately place upon events, and it can be treated through suggesting alternative, realistic thoughts. This formed the basis for cognitive therapy, and, coupled with ideas from behaviourism, the more recent, and increasingly significant, cognitive behavioural therapy of today (Pilgrim, 2011).

This desire to complement rather than contradict a biological perspective of depression is readily understood when one considers the enormous influence antidepressants have had in recent years. This cannot be understated; by 1994, fluoxetine, or prozac, was the second bestselling medication worldwide (Borch-Jacobsen, 2009). Given this, it is staggering to reflect on the fact that when the antidepressant effects of imipramine were first identified, the pharmaceutical company Geigy initially decided against financing further development of this drug as they believed the market would be too small. What has happened then, as Healy (1997) has documented, is that the dramatic increase in depression has paralleled the introduction and proliferation of antidepressant medication. This has led Healy to comment on how pharmaceutical companies not only "make drugs, but less obviously they make views of illnesses" (p. 181). One example he gives is how Merck, in order to market the drug amitryiptyline, marketed the actual

[8] For more on the historical development of statistics in psychology see Danziger (1990), and for a historical investigation of statistical thought see Hacking (1990).

concept of depression through the distribution of 50,000 copies of a book on the subject of recognising and treating depression.

While this kind of marketing alone is insufficient to explain the full extent of modern day depression, it seems reasonable to conclude, as Borch-Jacobsen (2009) does, that "depression is itself the product of antidepressants" (p. 203). Or, put more comprehensively:

> Given the many revisions of psychiatric nosology during the last thirty years, it is clearly a mistake to think that mental illnesses are something that have an established reality and that the role of a drug company is to find the key that fits a predetermined lock or the bullet that will hit an objective target. Although there are clearly psychobiological inputs to many psychiatric disorders, we are at present in a state where companies can not only seek to find the key to the lock but can dictate a great deal of the shape of the lock to which a key must fit (Healy, 1997, p. 212).

Clearly, antidepressants have left an indelible mark upon today's depression.

It is also important to reflect upon the way in which gender has influenced conceptions of melancholia and depression. For instance, this study began by alluding to a highly gendered portrayal of melancholia – the two Bethlem statues – from a time when both mania and melancholia were traditionally viewed as male oriented (Porter, 1995). In fact, Rousseau (2000) has claimed that "the genderization of madness is historically more significant that its medicalisation….madness had been primarily a male province until the eighteenth century" (p. 82). While not considered mad, the female character was considered to be naturally depressive (in an anachronistic sense) within Europe before 1800.

It was during the eighteenth century that women gradually came to be represented as mad and men, as depressed (Rousseau, 2000). Showalter (1987) has illustrated the former. She has shown how, since the Victorian era, insanity, including melancholia/depression, has been conceived of as naturally feminine both within psychiatric thought and within mainstream societal views, including the views of women themselves. This representation appears to remain: "Studies indicate that depressive episodes occur twice as frequently in women as in men" (APA, 2000, p. 354). The important point here is that depression has been intimately bound up with gender, and, at certain points in its past, can be considered a gender-specific malady. Raymond Prince (1967) has made a parallel observation regarding race; he has shown how, during the colonial era, European observers in Africa saw "very little melancholia or 'true

depression'; [whereas] the independence-period observers see depressions [sic] much more frequently" (p. 184). This further highlights the malleability of depression as a concept.

Even this brief consideration of depression and its history shows that it is not as well understood as one may originally think; it is highly contested rather than unanimously agreed upon, continuously renegotiated rather than set in stone, and relatively recent rather than age-old. How are we to make sense of this?

The work of Ian Hacking (2007) offers one potential explanation to capture the continual reconceptualisation of depression. He describes how, through classification, the human sciences can bring into being new types of people. He calls this *making up people* (p. 285). There are five aspects involved in this process: the classification, the people classified, the institutions involved, the knowledge produced and the relevant experts. However, people interact with their classifications and, in doing so, alter the classifications. This is called the *looping effect* (p. 286) and it leads to the classifications becoming what Hacking calls *moving targets* (p. 293).[9]

Returning briefly to antidepressants as an example, the view that depression has been produced by antidepressants becomes stronger with the benefit of Hacking's framework. Antidepressants can be viewed as knowledge produced by experts within institutions, which are then given to the people classified who in turn interact with the knowledge, experts and institutions, and, thus, alter the classifications. Here, depression may become that which responds to antidepressant medication. In this sense, antidepressants are involved in the *making up* of depression.

Multiplicity also has useful explanatory capabilities here. Instead of viewing the historical reflections presented as natural precursors to today's depression, we see a multiplicity of depression throughout history. Each subsequent concept of depression is necessarily a renegotiation, influenced by the field and theoretical orientation it emerges from, of what has gone before. This entails viewing depression's historical variation as the outcome of a complex network of power relations which continually reconstructs knowledge of depression, rather than being driven by ever-closer approximations to the truth of depression.

[9]Hacking previously reasoned that the *looping effect* occurred because people are human kinds as opposed to natural kinds. This idea was disputed (see Cooper (2004) for example). He has since abandoned this idea thinking there is no such thing as natural kinds so there cannot therefore be human kinds.

This brief historical review is unsatisfactory in many regards. It reduces the many nuanced and complex debates that have taken place regarding depression, and overlooks important social factors influencing depression. Clearly, these are extremely important for sophisticated understandings of this psychiatric object, but this would be a different project entirely. Historical reflections always involve a series of choices on the part of the author, both practical, such as the material to discuss, and theoretical.[10] Moreover, they can never be disentangled from their own social and historical context. One theoretical choice is to emphasise continuity or discontinuity. Here, I have attempted to illustrate some of the discontinuities in the history of depression, of which there are many. My thinking here is influenced by Foucault's work, particularly *The Archaeology of Knowledge* (1969). Hopefully some of the historical issues presented above will be informative for present purposes, to which we now turn.

Contemporary climate

Deep within *the Labour Party's* 2005 election-winning manifesto sat a rather vague commitment for continued investment in, and improvement of, mental health services (p. 64). This vagueness was soon to materialise into the unprecedented *Improving Access to Psychological Therapies* (IAPT) programme. IAPT was established to implement the *National Institute for Health and Clinical Excellence* (NICE) guidelines for treating depression and anxiety disorders using psychological therapy (Clark et al., 2009). This was a considerable investment leading to an increase in government funding of £173 million per year, and requiring the training of at least 3,600 new therapists (Clark et al., 2009).

The *Depression Report* was a key document in making the case for the benefits of psychological therapy and thus the IAPT programme (Layard et al., 2006). This report describes "crippling depression and chronic anxiety" as "the biggest causes of misery in Britain today" (p. 1). The report, while keen to emphasise value in reducing suffering, is largely based on an economic argument:

> the total loss of output due to depression and chronic anxiety is some £12 billion a year…of this the cost to the taxpayer is some £7 billion….These billions of pounds lost through inactivity are a huge cost when compared with the £0.6 billion a year which a proper therapy service would cost (p. 5).

[10] For reasons of space, I have chosen not to discuss important aspects related to depression here including evolutionary approaches, cross-cultural approaches and Seligman's (1975) concept of learned helplessness.

Viewing depression as "a major national problem" (p. 12), the report concludes asking readers to demand the implementation of the NICE guidelines from those in control of public expenditure. So, what is it, exactly, that readers should be demanding takes place?

The NICE depression

NICE have chosen to base their guidelines on the DSM criteria, largely because these criteria are employed in the majority of research (NICE, 2011, p. 17). The treatments within the guidelines are organised by type of intervention. The three main types are low-intensity psychosocial interventions, high-intensity psychological interventions, and pharmacological and physical interventions.

Low-intensity psychosocial interventions include computerised cognitive behavioural therapy – a form of cognitive behavioural therapy delivered using a computer which can be "the primary treatment intervention with minimal therapist involvement or as augmentation to a therapist-delivered programme" (p. 170); guided self-help – "a self-administered intervention designed to treat depression, which makes use of a range of books or other self-help manuals" (p. 182), and is facilitated by a healthcare professional; and physical activity – "a structured physical activity with a recommended frequency, intensity and duration….it can be undertaken individually or in a group" (p. 191). These interventions are "for people with persistent subthreshold depressive symptoms or mild to moderate depression" (p. 213).

High-intensity psychological interventions include cognitive behavioural therapy[11] – structured psychological therapy involving the identification and modification, via coping skills, of "problematic thoughts, beliefs and interpretations related to the target symptoms/problems" (p. 216); behavioural activation – a structured intervention designed to "reduce symptoms and problematic behaviours through behavioural tasks" (p. 239), such as reducing avoidance; and a range of other psychotherapies: couples therapy, interpersonal therapy, counselling, short term psychodynamic psychotherapy and rational emotive behavioural therapy. Cognitive behavioural therapy is preferred as it is said to have the largest evidence base (p. 291). These interventions are for those who have not benefited from low-intensity interventions and for those with moderate or severe

[11]Two other forms of cognitive behavioural therapy are also identified here: group based and mindfulness-based cognitive therapy, the latter being a group programme enabling "people to learn to become more aware of their bodily sensations, thoughts and feelings associated with depressive relapse, and to relate constructively to these experiences" (p. 216).

depression where the intervention should be combined with antidepressant medication (p. 297).

Pharmacological and physical interventions include a range of antidepressants: selective serotonin reuptake inhibitors (SSRIs), tricyclic antidepressants and monoamine oxidase inhibitors (pp. 329-330), and electroconvulsive therapy (ECT). If antidepressants are prescribed then SSRIs are typically preferred as they have a "favourable risk-benefit ratio" (p. 412), and ECT is recommended "for acute treatment of severe depression that is life-threatening and when a rapid response is required, or when other treatments have failed" (p. 526).

The IAPT programme, then, assists in the provision of these low and high-intensity interventions (IAPT, n.d.), and so it is these that are being advocated with such enthusiasm. More recently, IAPT has continued to receive political support. The current government confirmed £70 million for IAPTs third year, and an additional £400 million for the years up to 2014/2015, with talking therapies becoming a key part of their mental health strategy (Department of Health, 2011).

Clearly, IAPT has political importance then. This becomes even more apparent when considering the current political context – ostensibly characterised by austerity, localism and neo-liberalism. This raises the question of why IAPT is so politically appealing. Responses to this question could come from a variety of angles: it appears to be good economics, depression and anxiety are huge social problems, sufferers' deserve treatment and so on.

A more critical view may lead to questioning the social role of psychology, and other relevant disciplines.[12] One such question: does the development of IAPT provide a smokescreen for other governmental policies that are wholly opposed to the aims of IAPT? An affirmative response to this question does rather portray psychology as a villain, albeit a naïve, perhaps well-meaning, one. Also, it tends to overlook what happens at the level of the individual. For, after all, even if psychology is a smokescreen, is that not because it is doing something generally perceived as worthwhile? Moreover, what does this view mean for the person desperately seeking some kind of support, finding it in the IAPT programme and utilising this support to make sought-after changes? Surely, it would be inaccurate to dismiss this as just a convenient distraction from larger political changes.

[12]This line of critique has been pursued vigorously by some (see Parker (2007) especially).

These counter-questions quickly problematise viewing psychology as a mere political tool. And, even if this were a legitimate conclusion to reach, it does nothing to describe the relations between psychologist and patient, and the process by which these interactions serve wider political aims – surely an area worthy of attention in its own right.

At this point the work of Michel Foucault becomes particularly pertinent.[13] For Foucault's work allows this question to be asked the other way around: instead of asking how psychology is used politically we can ask how politics operates psychologically – although not ahistorically – and it is this that brings us to power relations. This seems a more sophisticated way of approaching these recent developments, and Foucault's work on disciplinary power in particular seems to offer useful analytic opportunities for attempting to understand this recent shift in the treatment of depression.

Discipline

In *Discipline and Punish*, Foucault (1977) discussed the emergence of a new form of power which he called disciplinary power. Disciplinary power operates subtly through institutional mechanisms and techniques with individuals coming to introject these techniques to regulate their own behaviour.[14] This form of power emerged when the system of rule shifted from the monarchical era of sovereignty to rule based upon the social body, a time when punishment was radically altered.

Punishment went from being a violent, public spectacle on the tortured body of the criminal, to a more specialised form based on discipline and incarceration. Humanistic reform aided this development with crime no longer seen as an attack on the sovereign but on society. With this, punishment became the responsibility of the social body and this led to a focus upon individual correction which required knowledge of the criminal.

Aspects of humanistic reform were incorporated into punishment which became focused on modifying behaviour through the specialist techniques of discipline: "Discipline 'makes' individuals; it is the specific technique of a power that regards

[13]Here I am thinking of *Discipline and Punish* first and foremost, but also his other work considering power such as *Psychiatric Power.*

[14]The word introject, with its psychoanalytic connotations, is not ideal here as it is being applied to a period that predates psychoanalysis. However, internalise would equally be problematic due its psychological connotations; Foucault opted for inscribe – see quote below. This point is not insignificant according to Butler (1989): "In a sense, *Discipline and Punish* can be read as Foucault's effort to reconceive Nietzsche's doctrine of internalization as a language of inscription" (p. 605).

individuals both as objects and as instruments of its exercise" (p. 170). It produces docile bodies "that may be subjected, used, transformed and improved" (p. 136).[15]

Disciplinary techniques

Discipline, then, made individuals obedient and useful. It did this through a variety of techniques initially found in the military, schools, hospitals, factories and prisons. Foucault discussed the operation of discipline by isolating "four great techniques" (p. 167).

The first of these was the *drawing up of tables* (pp. 141-149). This technique involved distributing individuals in space; sometimes a space closed in upon itself, but, more importantly, a space where each individual had a space and each space an individual. This allowed each individual to be known, assessed and judged, and also led to individuals being ranked in continuously changing positions. This technique had two important outcomes; it characterised the singular – the individual, and ordered the multiple – the group.

The second was *prescribing movements* (pp. 149-156). This technique controlled activities through the use of timetables. These timetables established routines, imposed tasks and regulated repetition. They were as detailed as possible and only contained worthwhile activities. This, of course, required supervision. For some tasks, particularly in the military, instructions were provided on where parts of the body should be at given moments, or how objects should be interacted with. This technique was not just a way of avoiding wasted time, but of striving to use time in an increasingly productive way.

The third technique was *imposing exercise* (pp. 156-162). Here, time was capitalised upon in specific ways. It was added up and divided into certain periods with each period having a specific end point. The tasks completed during each period increased in complexity and culminated with an examination. So the way in which exercise was employed was in an accumulative, graduated manner. Exercise, in this form, necessitated growth, observation and qualification.

The final technique discussed was the *arranging of tactics* (pp. 162-167). This was said to be the highest form of disciplinary practice, the calculated combination of a variety of forces. Here, individuals became elements placed in relation to others, and viewed as part of a bigger machine. Consequently, it was thought that something could be extracted

[15]In the past few decades, aided by Foucault and others, historians have focused on the body as a topic of research in its own right. See Crozier (2010) for example.

from individuals at all times. This was achieved through the creation of signals to which, once perceived, an individual responded immediately and appropriately.

Disciplinary instruments

In addition to these techniques, Foucault identified three major instruments of discipline: *hierarchical observation, normalising judgement* and *examinations*.

Discipline relied upon surveillance and hierarchical observation was to provide this. Surveillance, in an idealized form, would allow a single gaze to see everything at all times, but it was a system based upon integrated hierarchies of observation which proved most efficient. This established a network of relations with power produced more as a result of the particularities of the system than due to the individuals within it. Even supervisors were perpetually supervised and so potentially expendable.

Normalising judgement involved making even minor deviations from the desired behaviour subject to some form of punishment. This meant that failing to achieve an expected level on a task could be considered worthy of punishing, with the appropriate punishment for this kind of offence being exercise and further training. This led to a situation where "rank in itself serves as a reward or punishment" (p. 181). As a result, deviating from normality became a new form of punishment within disciplinary power.

The examination combines both the hierarchical observation and the normalising judgement and is of central importance in the techniques of discipline. It is through the examination that power holds subjects "in a mechanism of objectification" (p. 187). With the examination, there was a reversal in the relations of the documentation of individual lives; the object of writing became the child, the patient, the madman and the prisoner instead of, as previously, the king and the hero. This is what Foucault calls "the reversal of the political axis of individualization" (p. 192), and it was this that enabled the growth of the sciences of man. The examination provides each individual with a unique individuality and so here the productive aspects of power can be seen; power "produces reality; it produces domains of objects and rituals of truth. The individual and the knowledge that may be gained of him belong to this production" (p. 194).

Foucault illustrates the ideal form of disciplinary power through the architectural arrangements of Bentham's Panopticon (pp. 195-228). Here, individuals, or subjects as Foucault prefers, were knowingly exposed to conditions of permanent surveillance, without being able to see their observers. Subjects could be carefully observed and compared at all times and so the Panopticon had a dual-purpose: experimentation and

observation. The efficiency of this technology was such that:

> He [sic] who is subjected to a field of visibility, and who knows it, assumes responsibility for the constraints of power; he makes them play spontaneously upon himself; he inscribes in himself the power relation in which he simultaneously plays both roles; he becomes the principle of his own subjection (pp. 202-203).

The Panopticon embodied a form of power that was exercised by the social body as a whole. It could be democratically controlled with members of the public visiting the Panopticon to observe both the observed subjects and the observers themselves. These mechanisms of discipline extended throughout the social body infiltrating all other forms of power thereby creating a "disciplinary society" (p. 216).

The rationality underlying discipline, with its need to know the individual, opened up a space for the specialist study of humans, and, thus, shows the interlinking of power with knowledge – an important aspect of Foucault's thought. One implication of this is that the human sciences have at their foundation particular power relations which the modern individual we know today – a product of the knowledge of the human sciences – has emerged from. This partly explains Foucault's discomfort in utilising psychological discourse to discuss relations occurring before the advent of psychology.

Aims

As intoxicating as Foucault's portrayal of disciplinary power is, at least to those inclined to his methodological preferences, it can be rather easy to generalise. Foucault argued that the human sciences were institutions involved in the production of disciplinary power, and his linking of power-knowledge makes this hard to refute. Accepting this, however, it is easy to develop a univocal position towards these disciplines and thus to turn away from the minutiae of the disciplines' specific practices,[16] already certain that they are merely extending unjust power relations. What I intend to do here is to turn towards these specific practices, to analyse the legitimacy of disciplinary power conceptually when applied to a particular practice – the treatment of depression.

The main aims of this study, then, are twofold: firstly, to investigate the extent to which treatments of depression can be considered contemporary forms of discipline, and, secondly, to analyse the utility of discipline as a concept for thinking about specific aspects

[16] This is not to say that this is what Foucault was advocating, as he does emphasise the heterogeneity and multiplicity of these various technologies, but more a potential response to his ideas.

of the human sciences. This research begins from the position that treatments of depression are not simply clinical decisions, but involve a range of social, political, institutional and historical factors, and, thus, need to be engaged with from a variety of angles and perspectives. It is one such angle that will be adopted here with the aim of being able to speak to and complement, rather than contradict and antagonise, clinical work.

Analysis

As described above, there are a wide range of potential treatments available within the NICE guidelines. However, due to space requirements, only four of these treatments will be analysed here. These treatments will be from the low intensity and high intensity sections of the guidelines and are therefore interventions that the well supported IAPT programme provides. Two of the low intensity treatments and two of the high intensity treatments will be analysed: computerised cognitive behavioural therapy, guided self help, cognitive behavioural therapy and behavioural activation. Each treatment will be considered in relation to the *four great techniques* discussed above, and, following this, these treatments will be considered collectively in relation to the instruments of discipline.

Computerised cognitive behavioural therapy

Computerised cognitive behavioural therapy (CCBT) is a structured form of treatment that follows the same principles as CBT. It is accessed via a computer programme and thus input required from professionals typically involves introducing the programme, brief monitoring and being accessible to the user. A programme called *Beating the Blues* is identified by the NICE guidelines as a suitable treatment (p. 180).

A study by Proudfoot et al. (2004) describes the format of *Beating the Blues*. It consists of a 15 minute introductory video and then eight weekly sessions of therapy. The sessions last around 50 minutes and provide work to complete between sessions. These sessions are "customised to the patient's specific needs and each session builds on the one before" (p. 46). The programme provides a report of the patient's progress for the patient and the GP at the end of each session, including whether suicidal ideation is present. The programme contains cognitive components, such as challenging unhelpful thinking, and behavioural components, such as activity scheduling.

In terms of the first technique, the drawing up of tables, it can be seen that CCBT distributes individuals in space in a particular way. This is an activity that positions each individual in front of a computer. This is paradoxical in its effect. Placed alone, in front of

a computer, this activity seems in many ways private with subjects being able to think and work at their own pace. Yet data is simultaneously collected by the programme and progress reports are printed for GPs so it is ultimately not a private activity but an observed one. It is also not the case that each space has an individual. In fact, computers can be, and often are, shared spaces. But, thinking of space at a more minute level, as a space on the programme rather than physical space, each individual does have a unique space and vice versa. The progress reports also allow ranking of individuals, and the efficient data collection provides each subject with a unique individuality, their report information, while continuously expanding and contracting knowledge of the group as a whole.

The second technique, prescribing movements, can also be mapped onto CCBT in some ways. Firstly, CCBT provides individuals with a weekly therapy session and tasks to complete between each session. This entails an element of routine and the imposition of tasks. Some components of CCBT may extend this further. For example, activity scheduling, mentioned above, can be viewed in some ways as a timetable, and can certainly cover the entirety of a person's time. However, this treatment lacks control over the implementation of this. For example, subjects weekly sessions of CCBT can be monitored to see if they are attending, but supervision of tasks outside of this time rely upon the cooperation and consent of subjects. At face value then, this seems to imply greater autonomy to subjects than the prescription of movements Foucault had in mind.

The third technique, imposing exercise, also has some resonance with CCBT. The treatment lasts eight weeks and is divided into weekly sessions. As each session builds upon the previous session, this form of exercise occurs in a graduated fashion. This entails subjects to progress through the programme improving at the tasks as they go along. However, there is no mention of a final examination, only the same report that is generated at the end of each individual session. Nevertheless, it can be seen that CCBT does in some ways imitate modular educational training courses.

Foucault's final technique, the arranging of tactics, is less immediately applicable to CCBT. While individuals can be placed in relation to each other through the reports generated by these programmes, it is hard to see what is being extracted from them other than information, which recalls the power-knowledge dichotomy. Perhaps, though, this is a remedy to restore these subjects to a state where they are able to produce something of social use, which *The Depression Report* certainly seems to imply. Be that as it may, this technique remains ambiguous in relation to CCBT.

Guided self-help

Guided self-help is a form of treatment that individuals administer to themselves through the use of books and manuals. It is introduced, monitored and reviewed by a healthcare professional and involves between three and six contacts (p. 182). No specific resources are recommended within the NICE guidelines. As a result, I have selected a self-help guide co-authored by one of the key figures in developing the IAPT curriculums (Richards & Whyte, 2009).

This self-help guide is split into four sections: understanding the way you feel, finding out about depression and low mood, ways to improve your mood and staying well (Lovell & Richards, 2011). Users are encouraged to read the first two sections, make choices in the third section and use the final section when feeling better. People are expected to use this guide while receiving support from a "self-help coach" (p. 8), their GP, and friends and family. The advice given includes keeping written records, making a step by step plan of recovery, doing something every day, regularly talking to people about how things are going, and trying different ideas from the guide if particular ones are not working. Users are recommended to set themselves goals and the guide provides a list of things to do and to avoid in the areas of sleep, diet, irritability, energy and concentration levels. The guide, like CCBT, provides two main techniques for changing the way a person feels. The first, behavioural activation, focuses on establishing daily routines and increasing pleasurable activities. The second, cognitive restructuring, focuses on noticing and challenging unhelpful thoughts.

Guided self-help, in many ways, seems inconsistent with the drawing up of tables. There is no additional space for individuals to enter or be placed within and no space waiting for individuals. The guided part of the self-help can take place over the telephone, via email, or face-to-face, but, apart from that, this treatment takes place in the space in which subjects reside on a daily basis. Despite this, the treatment does allow each individual to be known, assessed and judged. This is done through their own regular communications of their progress and through the worksheets contained within the self-help guide. If this is the function of this technique it is achieved with little spatial modification. Furthermore, there is an individualising effect in that each subject selects their own goals and tasks.

Prescribing movements is more easily identifiable. The guide encourages, but does not compel, individuals to do something every day. This is not as detailed as the level of movement prescription Foucault identified but is reminiscent of it. Behavioural activation

clearly establishes routine and regulates repetition to some degree; this will be explored in more detail below. The cognitive restructuring task makes use of a thought diary to collect and record thoughts. In addition to recording thoughts, individuals are required to write down the situation they were in at the time of the thought, the associated emotion(s), to rate how bad the thought was, and, how much the thought is believed to be true, both from 0-100%. Following this, individuals are to "collect evidence" for their thought, giving the thought a "fair trial", and once completed to reconsider the truth of the initial thought (p. 38). The focus on rationality is immediately evident here, as is the intimate and detailed nature of this task. Supervision is emphasised as preferable here too. Foucault's second technique does not adequately capture what is going on here. Rather than prescribing movements, this task is prescribing mental activity in a detailed and restricted way. This is an operation less on the body and more on the thoughts of the individual instead.

In terms of imposing exercise, guided self-help is similar to CCBT. Three to six contacts are recommended and so treatment time is divided up with a specific end point. The two individual techniques of behavioural activation and cognitive restructuring are graduated and the layout of the guide progresses in a way that implies growth with the final section being dedicated to ways of staying well. The idea of goal setting is also relevant here. Although it does not lead to a formal examination, it can be viewed as a way of imposing exercise and testing oneself. As a technique this seems in some ways more effective than Foucault's version. The examination is not imposed upon a subject but is collaboratively agreed upon by the self-help coach and the subject. This requires a more active participatory role for the subject and thus potentially less resistance. As does the recommendation that individuals' complete a mood questionnaire if they begin to feel low in mood again. These strategies place greater emphasis on subjects acting on their own volition than Foucault's techniques.

Not mentioned yet, but relevant here, the self-help guide contains "recovery stories" documenting the ways in which the self-help techniques have improved aspects of people's lives (pp. 44-64). This resembles the arranging of tactics. Those using the guide can place themselves in relation to these recovered individuals. They can see the impact depression has had on a range of other people, and view themselves as part of a group of people affected by depression, albeit in unique, individual ways. Also, these recovery stories show ways in which individuals began to meet their goals. These included a woman taking her son to the park twice a week, another woman joining a night class, and a man feeling confident enough to meet his old colleagues. Thus, in some senses, and in line with

this technique, these individuals have become productive, or docile, again. The importance stressed upon ongoing monitoring of mood can also be viewed as the creation of signals, which, when perceived, leads to individuals re-initiating these techniques.

Cognitive behavioural therapy

Cognitive Behavioural Therapy (CBT) is an educational form of therapy where people learn to recognise and revise unhelpful thinking styles and behaviours. It attempts to address any problematic beliefs underlying the presenting issues, and requires patients to practice what they have learnt in therapy in between sessions. In CBT, patients work collaboratively with therapists with the aim of being able to identify, monitor and counteract problematic thoughts, beliefs, feelings and other problem areas. This is typically done over 16 to 20 treatment sessions and most of the studies informing the NICE guidelines were based on the work of Beck et al. (1979).

The contemporary treatment for depression following the Beck model begins with the therapist assessing the patient, familiarising the patient with the cognitive model and dealing with the patient's pessimism (DeRubeis, Webb, Tang & Beck, 2010). The patients' level of depression is assessed in each weekly session to monitor any changes a patient makes during therapy. Patients are asked to read about the cognitive model of depression and to discuss their reactions to this with their therapist. Tasks are completed that patients have not been able to complete independently, and patients' expectations towards task performance are discussed and monitored. As therapy progresses, patients are asked to identify situations and thoughts that lead to them feeling depressed. This is typically done using a *Daily Record of Dysfunctional Thoughts* where patients begin to question their thoughts during or following a negative emotional experience. The therapist supports this process by reviewing the daily record in sessions. This is further supplemented by exploring patients' idiosyncratic assumptions in interpreting events within their lives. Towards the end of CBT, progress is reviewed and the focus moves towards preventing relapse. Future potentially difficult situations are discussed to consolidate patients' coping skills, and ending therapy is discussed with increasing responsibility for the treatment being given to patients. Follow up sessions, ranging from once per month to three times per year, are also arranged to prevent relapse.

In relation to drawing up tables, the key space that this treatment uses is the therapists consulting room. This is a space that is used not for a single individual but for a potentially never-ending queue of subjects. This is not the same as Foucault's drawing up

of tables. A relevant feature of CBT is that each individual is linked to an individual therapist. In Foucauldian terms, each subject has a master. This is more reminiscent of Foucault's (1978) later work discussing the confessional than the disciplinary techniques described above. Although Hook (2007) describes the confessional as a disciplinary instrument in the verbal mode rather that the visual mode, which involves an additional element of speaking subjects turning themselves into discourse and thus constructing themselves through "given norms of identity" (p. 36). These surface differences between CBT and the drawing up of tables may be relatively unimportant if they both have the same outcome: each individual is definitely known, assessed and judged. There is also an individualising effect here, which is encouraged in the desire for subjects to take responsibility for their own treatment. The desire to make individuals into their own therapists closely relates to Foucault's chilling description of the ideal form of disciplinary power. In this situation, subjects would be playing both power roles and becoming the principle of their own subjection.

Movements are prescribed within CBT. There is the obvious routine of weekly therapy for 16-20 weeks. In addition, there are tasks to be completed between sessions: the most significant of these being the *Daily Record of Dysfunctional Thoughts*. This is a more intimate activity than the military tasks Foucault described. For therapy to be deemed successful, subjects are required to attend closely to their emotions and accompanying thoughts, and to record them accurately and obediently for the therapist to scrutinise. Again, this recalls the confessional. Extending Foucault's technique, the most important objects interacted with here are individuals' thoughts which should be dealt with in particular ways. Prescribing movements encourages individuals to use time in an increasingly productive way and CBT teaches people to spend a great deal of time reflecting on their own thoughts. From the perspective of discipline, this can be viewed as a useful way of rendering individuals docile and achieving a situation where they come to regulate not only their own behaviour but their own thoughts too. This pushes Foucault's discipline to another level. Operating first and foremost on the thoughts of individuals, as opposed to the body, if this distinction can be made, is surely a more insidious and effective strategy.

CBT imposes exercise in well-defined ways. A 16-20 week block is divided into equal periods with one session in each. Between sessions, individuals have work to complete on a daily basis. Each session contains a form of examination – an assessment of any change in mood. In accordance with its educational style, CBT operates in a graduated

manner. At the start of therapy, individuals are socialised to the CBT model and style of thinking and towards the end of therapy are expected to be starting to take responsibility for the treatment themselves. This therefore necessitates growth, observation and some form of qualification. More than this, it necessitates an ongoing self-observation. The end of therapy is more flexible and ambiguous than a simple examination. Rather, additional sessions of therapy can be arranged based upon the needs of each individual. So, deviation from Foucault's technique is again evident.

In terms of arranging tactics, CBT definitely creates signals for individuals to perceive and respond to. These signals are the emotions and thoughts of individuals. As described above, subjects are taught to recognise and challenge thoughts that are linked to negative emotions as soon as possible. CBT is also based upon a particular conception of what it is to be human and what humans are. That is, humans are cognitive beings whose behaviours, thoughts and emotions are closely interrelated and amenable to change. Also, negative emotion is not to be tolerated and to be extinguished via a form of rationality that critiques negative thoughts. Here, subjects exposed to CBT are all these types of beings, and are individual elements within a bigger machine. So, CBT can be viewed as a form of disciplinary practice based on this technique.

Behavioural activation

Behavioural activation is one of the techniques contained within the self-help guide and a version of this, activity scheduling, is part of the CCBT programme. It will be discussed in more detail here as it is a recommended high-intensity intervention in the NICE guidelines. Behavioural activation is based upon the idea that depression results from a lack of positive reinforcement and is maintained through negative reinforcement. This intervention seeks to remedy the situation by breaking patterns of negative reinforcement, increasing pleasurable activities, and increasing task-focused behaviours.

One of the studies informing the recommendation of behavioural activation as a treatment for depression within the NICE guidelines will be considered here. It describes the steps involved in the implementation of this intervention (Hopko, Lejuez, Lepage, Hopko, & McNeil, 2003). Firstly, information is gathered about the function the depressed behaviour is serving, rapport is established with the patient, and the treatment rationale is introduced. Then:

> an activity hierarchy is constructed in which up to 15 activities are rated ranging from *easiest* to *most difficult* to accomplish. Using a master activity log…and

> behavioral [sic] checkout to monitor progress (similar to the master log but kept in the presence of the patient to enhance accountability and compliance), the patient moves through the hierarchy in a systematic fashion, progressing from the easiest through the most difficult behaviors. At the start of each session, the behavioral checkout form is examined and discussed, with the following daily goals being established as a function of patient success or difficulty (2003, pp. 461-462).

In this study, patients had three 20 minute sessions per week with clinicians to assess their progress and make any necessary modifications. The treatment lasted for two weeks.

The drawing up of tables can be seen with this treatment, although in a slightly different form to the one Foucault articulated. There is the space of the clinic where the patient has sessions with the clinician. This is a space that is more flexible than being reserved for one individual though. Also, the spatial effects of this intervention seem infinite in possibilities. There are 15 activities selected and these activities are not predetermined but chosen together between patient and clinician. Thus, two individuals receiving this treatment may never experience it in exactly the same way. The individualising effects of this are clear, but the spatial requirements are fluid and potentially limitless. Despite this, each individual can still be known, assessed and judged so the outcomes of this treatment and Foucault's technique may well still be the same.

This treatment, of all those considered, must surely be the most similar to prescribing movements. It fits this technique almost entirely. It establishes routines, imposes tasks and regulates repetition. In the timetable example provided in the above study, tasks are as short as 10 or 20 minutes in duration so this treatment has the potential to be extremely detailed. The activities are also to be pleasurable and task focused and so time is being used in productive ways, although productive for the individual rather than the clinician. The treatment is also well supervised meeting a further criterion of the prescribing movements technique. If there is an area where this treatment differs from Foucault's technique then it must be in the subject's involvement. Although the treatment strives for compliance, it also requires rapport to be established. This shows that the subject takes an active role in this treatment, which was not the case in Foucault's description.

Behavioural activation also resonates with imposing exercise. The treatment divides time in particular ways. There is the time that is used for activities, and then the important, regular reviews of patients' progress. The treatment is also relatively short in duration, two weeks in this instance, so the different periods of this treatment are clearly defined.

Furthermore, the tasks are to be completed in an obviously graduated manner. Growth is a consequence of this treatment as tasks are rated according to level of difficulty; an individual begins with the easiest tasks and gradually progresses to the most difficult tasks. There is also a form of examination as at the beginning and end of the treatment individuals depressive symptoms are assessed. Of course, this is not a test of how well individuals perform the activities, as it was in Foucault's imposing exercise, but it is, nonetheless, a form of examination.

The arranging of tactics fits this treatment less obviously. The master activity log can be viewed as a signal for individuals to respond to, and the attempt to extract something from individuals at all times is present. But it is not necessarily something that has any immediately tangible benefits to the clinician. After all, what does a clinician gain if an individual goes for a walk or gets out of bed? However, it would be a mistake to think that the lack of immediate benefits to the clinician means there are none whatsoever. Conformity is sought after, and ultimately necessary, for the perceived success and continued influence of this intervention. It may be that the clinician's profession, and therefore the bigger machine of IATP, benefits from individuals' compliance with behavioural activation in that it shows the value of the profession. And, it may have the eventual outcome of rendering a subject fit to contribute to society once more.

Disciplinary instruments

It is clear that these treatments also relate to the instruments of discipline – hierarchical observation, normalising judgement and the examination – in numerous ways.

Hierarchical observation is built into all of these treatments. The first level of observation occurs at the level of subjects themselves though, something not specified by Foucault. In fact, this seems to be one of the key differences between these treatments and Foucault's techniques. All these treatments require the recipients' to observe themselves. Beyond this, there is a hierarchy of observation – a self-help coach, a GP, a therapist, and further up the chain, the supervisors of these professionals. Power operates here through this dispersed network, through this set of arrangements that does not necessarily require any of the individuals within it to operate, but just the structure of the system itself. But, this is just in the abstract, as a system devised on a blank piece of paper. When you add individuals into this system, it will not remain a static machine but will be pulled in different directions by the individuals interacting with it – something that Hacking's ideas, discussed earlier, capture.

The normalising judgement is also identifiable within these treatments. The distinction between low and high-intensity treatments reflects this as these are designed for people with different levels of depression. So, from this angle, we can say that these treatments are punishments for severity of depression. For example, as the NICE guidelines specify, failing to respond to a low-intensity treatment makes someone appropriate for a high-intensity treatment. Being in treatment equates to deviating from normality and this reinforces the long-standing binary of normal/abnormal. Nowhere is the distinction between normal and abnormal more noticeable than in the DSM, which informs the NICE guidelines. A diagnosis from this manual can be considered the ultimate form of punishment from the perspective of the normalising judgement.

The examination, too, features within these contemporary treatments of depression. This is in fact a central component of these treatments as it allows individuals to be differentiated from one another, the severity of their depression to be known, and their response to treatment to be monitored. The individualising effects, as discussed throughout, are clearly taking place as is the growth of knowledge of the individual. The examination in this context though is not an examination of individuals' abilities, but of their mood, giving an increasingly detailed knowledge of the depressed individual.

Where does this leave us?

At this point, it seems reasonable to conclude that contemporary treatments of depression can be considered disciplinary techniques. The treatments discussed have much in common with disciplinary techniques. They individualise, they are graduated, they allow individuals to be known, assessed and judged, they involve dividing time in well-defined ways, they employ the use of tasks and routine, and so on. Accordingly, the IAPT programme can now be considered from an alternative perspective. Instead of being the consequence of political motives, malign or not, IAPT can be viewed as a contemporary incarnation of discipline and so an important part of the social body. It aligns with political aims, operates on individuals in sophisticated ways and, in the process, produces or, recalling Hacking, *makes up* a particular type of person. Like antidepressants discussed earlier, the IAPT programme is involved in *making up* depression. Mental health professionals actively shape the clinical features of depression, and "psychotherapists no less than the pharmaceutical industry coach both their colleagues and the potentially treatable population as to the currently most appropriate clinical presentations" (Healy, 1997, p. 212).

But, there are also points of divergence between these treatments and Foucault's techniques. For example, the treatments provide greater autonomy for individuals (however, this is something which Foucault's later elaboration of power certainly provided for – see below), they use space in a more flexible and less constrained manner, there are no final examinations but ongoing monitoring and self-assessment, they attend more to the thoughts of individuals, and there is nothing tangible being immediately extracted from individuals, although IAPT certainly benefits from this process. So IAPT is not wholly reducible to disciplinary techniques.

While Foucault's disciplinary techniques do not perfectly correlate with these treatments of depression, elements of the techniques do permeate the treatments discussed. What does this mean? Foucault was discussing the emergence of discipline as the system of rule shifted from the era of monarchy to the era of the social body, which roughly coincided with the Enlightenment. That was a long time ago, but, clearly, traces of discipline are to be found in contemporary practices. Does this reflect the historical accuracy of Foucault's descriptions? If our society has grown out of these practices, is it therefore to be expected that discipline infiltrates numerous aspects of modern life? Perhaps. But, also, it could be the case that Foucault was describing something important that, then, as now, partially captured the reality of life, but not wholly.

From this perspective, we can retain and move away from Foucault's ideas simultaneously. One area where this needs to be done is in the role of, what we call today, individual psychology. Foucault was reluctant to draw upon psychological description in his analyses to avoid being anachronistic and to avoid developing an ahistorical model of human psychology. However, a lack of any kind of individual psychology leaves an important aspect of disciplinary techniques unexplained. How do individuals "assume responsibility for the constraints of power" (p. 202), or introject power relations without some form of psychology? If that were possible, then would those individuals not already be docile?

Judith Butler (1997) is one of many who have probed this issue. She states that, in trying to dismiss the possibility of a body being produced outside any power-relations, Foucault's explanations sometimes "require a body to maintain a materiality ontologically distinct from the power relations that take it as a site of investment" (pp. 89-90). She goes on; "perhaps Foucault himself has invested the body with a psychic meaning that he cannot elaborate within the terms that he uses" (p. 95). For her, there is a psychic excess, which can lead to resistance, not adequately accounted for by Foucault.

Nikolas Rose, whose work is deeply influenced by Foucault (see Rose, 1999 for example), has provided an alternative way of thinking about this problem. Drawing upon Deleuze, Rose (1996) contends that we can best think of individuals' inner psychology as a "discontinuous surface, a kind of infolding of exteriority" and not a psychological system (p. 37). He uses this concept of the fold to suggest a way of thinking of "an internality being brought into existence in the human being without postulating any prior interiority", and these folds "incorporate without totalizing, internalize without unifying" (p. 37). This process allows a variety of responses to the experienced exteriority and so can account for resistance and agency often viewed as lacking in Foucault's work; no theory of agency is necessary, particularly in relation to resistance, as people "live their lives in a constant movement across different practices that subjectify them in different ways" (p. 35).

Hook (2007) reminds us of the importance of attending to this psychic excess, infolding of exteriority, or individual psychology; "if there is no significant psychological individuality *prior* to that affected by power, then surely all subjects would react in a largely similar way to the implementation of its effects?" (p. 48). His position is that the effects of discipline are psychologically complex and so require some sort of psychological explanation. He is keen to retain an emphasis on discipline as a way of considering the extent to which the psychological falls under the realm of power, but wonders whether certain non-humanistic psychological concepts, applied in an exploratory manner, may help to fill in some of the blanks left in Foucault's work.

The extent to which these approaches fully resolve the difficulties they raise is a matter for debate. But it does seem that this is an area that cannot be sidestepped in the way Foucault did. For if we want to accurately capture the effects of discipline and power we require some articulation of the interaction between, in this case, patient and therapist to fully understand the complexity of this process. What is also important here is that these approaches bear similarities with this study in their desire to utilise yet refine Foucault's thought. As evidenced, Foucault's work has the potential to enrich understandings of the treatments of depression through a consideration of the ways in which power is invested in these treatments. Yet his work alone is not enough to fully capture the entirety of these treatments in their multiplicity and complexity.

Technologies of the self

It should be noted that this has been an investigation into practices of domination of the individual, what Foucault (1982) called "the objectivizing of the subject" (p. 208). In

his later work (1978), he moved away from this approach somewhat to study the ways people turn themselves into subjects via technologies of the self. These technologies:

> permit individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection or immortality (1988, p. 18).

It is through our attachment to technologies of the self, Rose (1996) argues, that "we are governed by our active engagement in the search for a form of existence that is at once personally fulfilling and beneficial to our families, our communities, and the collective well-being of the nation" (p. 78).

This shift in Foucault's (1978) emphasis also led to him elaborating his descriptions of power, focusing more on the productive aspects of power: power is "produced from one moment to the next, at every point, or rather in every relation from one point to another. Power is everywhere; not because it embraces everything, but because it comes from everywhere" (p. 93). Accordingly, power permeates all aspects of life. It is produced through everyday interactions between people and institutions; power is a system of relations within society which needs to be continuously performed in order to be maintained (Mills, 2003). This refinement of the concept of power brings with it the expectation of resistance: "it would not be possible for power relations to exist without points of insubordination which, by definition, are means of escape" (Foucault, 1982, p. 225). There is a "perpetual linking and a perpetual reversal" between power and resistance (p. 226).

Foucault (1988) suggested that practices of domination and technologies of the self function simultaneously. Studying contemporary treatments of depression seems to support this notion. In fact, some of the main points of divergence between the treatments and disciplinary techniques seem to be legitimate examples of technologies of the self: the greater autonomy given to subjects, self-observation, and subjects taking responsibility for their own treatment. Perhaps, then, technologies of the self and the productive aspects of power play an important, complementary role with disciplinary techniques in the governing of the modern individual. But even with this new emphasis on the government of the self, these techniques remain, ultimately, types of domination which potentially limit the opportunities to work alongside clinical approaches. As a way of employing the key insights of Foucault's work and yet not being *governed by them*, I would like to return to Annemarie Mol's notion of multiplicity in relation to depression.

Multiplicity

This study does a number of different things. It looks at different conceptions of depression, briefly considers depression's history, engages with contemporary political factors influencing the way depression is treated, explores the current treatments of depression, analyses these treatments as disciplinary techniques, and discusses other aspects of Foucault's work. In short, it looks at depression from a variety of angles, precisely because depression has a variety of sides to it. That is, depression should best be thought of as an object of multiplicity. It is, like Mol's (2002) atherosclerosis described above, singular and multiple at the same time. This is what allows these numerous aspects of depression to be discussed yet somehow for them to remain cohesive. Even the DSM's depression is multiple yet typically understood, clinically and socially, as singular.

Mol describes how objects are *enacted* in practice. This enables a move away from describing the *construction* of objects, which can often lead to a focus purely on discourse. "Talking about the enactment of objects builds on and is a shift away from another way of talking about objects, one in which the term *construction* has a prominent place" (p. 41). This allows objects to be viewed as having complex *identities* which differ across time and place. But also, objects, like depression, are real because they are part of a practice, a reality enacted. From this view, depression does not have a natural essence, but is enacted in a multiplicity of practices. It is a few of these practices that I have considered here.[17] The objects and materiality of these practices are just as important as the people involved. In Mol's case, this meant that the microscope is an indispensable part of the multiplicity of atherosclerosis. With depression, this might mean that the actual practice of therapy is an indispensable part of the multiplicity of depression.

Multiplicity also prioritises the local rather than the universal. Whatever an object is, it is something that is situated in a variety of practices specific to a time and place. So, although Mol does not specifically attend to the historical development of atherosclerosis and can be critiqued for overlooking this, multiplicity requires a historical and material approach to understanding objects. As we have seen in the case of depression, historical engagement is absolutely vital for an in-depth understanding of such objects. Without this, we would not have seen the extent to which contemporary depression has been *made up* by Kraepelin's ideas, psychoanalysis, antidepressants, and more recently CBT; and that these

[17] Although I have done this is in the abstract through analysing texts rather than actual clinical practice. It seems plausible to expect that the multiple aspects of depression seen in this study would multiply further in clinical practice.

historical factors were part of wider social changes which only retrospectively appear inevitable. Historical reflections also demonstrated the gender and race specificity of depression, both significant aspects of depression's past. Multiplicity also encourages a consideration of the different fields – psychology, psychiatry, patient etc – which have interacted with depression.[18] Finally, it places issues of power and politics on an equal footing with clinical issues and research in the enactment of depression and can therefore retain in a constructive way the insights of Foucault's work.

I have tried to add to the multiplicity of depression by considering these treatments as disciplinary techniques. This encourages reflection on the importance of issues of power and politics in the area of mental health, but attempts to do so in a way that is not insensitive to the range of social and clinical practices trying to provide support for distressed individuals. I have attempted to broaden discussions of depression and its treatment in a serious, but not antagonistic, way that, as mentioned earlier, can speak to clinical practice.

Conclusion

Depression is a psychiatric object that is conceptualised in a variety of ways from a variety of theoretical perspectives. It has a complicated and nuanced history which illustrates the extent to which depression is a fragile object that has not always been with us and is subject to change. It is nonetheless an important topical issue, in the political arena as well as the clinical one. This study has used the work of Michel Foucault to attempt to add another angle to thinking about today's treatment of depression. This was done by analysing four contemporary treatments of depression as disciplinary techniques. These were computerised cognitive behavioural therapy, guided self-help, cognitive behavioural therapy and behavioural activation.

The analysis carried out here has shown that these treatments share many features of, and so can be considered, disciplinary techniques. This raises the importance of thinking about issues of politics and power when thinking about psychiatric and psychological treatment. It would be naïve and potentially harmful to view these

[18] I have also spent very little time considering depression from the perspective of the patient which would be a different project entirely. In overlooking this, I hope not to have given the impression that patients are merely obedient subjects, and Hacking's framework and Foucault's technologies of the self and productive aspects of power are sophisticated ways of reflecting upon the influence patients have in the enactment of depression and its treatment.

treatments as purely based upon developing scientific and clinical knowledge; they are intimately bound up with wider social and political issues. This needs to be accounted for in both clinical and socio-political reflections upon depression.

This analysis has also interrogated Foucault's disciplinary techniques themselves and shown that there are some limitations to using them as analytical tools. They are extremely important in showing the extent to which power relations are dispersed throughout society, but they lack the sensitivity to capture the entirety of modern day treatments. Combined with technologies of the self and the productive aspects of power, disciplinary techniques are more fully equipped for this task. Nevertheless, this results, ultimately, in viewing the practices of the human sciences as ones of domination. This is unsatisfactory, however, when attempting to engage with and improve clinical practice. Multiplicity offers a solution.

Today's treatments of depression are disciplinary techniques, but they are also more than this. They are multiple. They are the routine practices that take place between GP and patient, therapist and client, self and computer. They are inextricably interlinked with political and economic interests but they are also about enabling a person to get out of bed in the morning. Approaching treatments from a view of multiplicity allows these different aspects to be viewed with equal importance in the enactment of contemporary depression. This has the potential to retain the original and important insights of Foucault's work while also stressing the multifaceted, everyday practices involving depression. This should enable a broader and narrower view of depression that could go a long way towards improving the theoretical understanding and clinical treatment of this complex, ubiquitous object.

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